FAMILY PLANNING PROGRAM – REGISTRATION FORM

First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: _____ Maiden/Former Name: _____

Address: _____ Unit #: _____

City: _____ State: _____ Zip: _____ County: _____

Is it OK to send mail to this address? Y N

Phone: _____ *(home, cell, work)* OK to Leave Message? Y N Text? Y N

Alternate Phone: _____ *(home, cell, work)* OK to Leave Message? Y N Text? Y N

Email Address *(optional)*: _____

Emergency Contact Information: Please tell us who to contact in case of emergency (parent or guardian if under 18): An emergency would be severe bleeding, unconsciousness, accident or a condition requiring ambulance transport or hospitalization. ***Family planning services DO NOT require parental permission***; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian.

Emergency Contact Name: _____ Phone Number: _____
Does the person above know that you are receiving services here? Yes No

Ethnicity *(check at least one):*
- □ Hispanic Origin
- □ Non-Hispanic Origin

Race *(check at least one):*
- □ American Indian/Alaskan Native
- □ Asian
- □ Black/African American
- □ Native Hawaiian/Pacific Islander
- □ White

Primary Language:
- □ English
- □ Spanish
- □ Other:_____

What is your gender identity:
- □ Female
- □ Male
- □ Transgender Male/TransMan/FTM
- □ Transgender Female/TransWoman/MTF
- □ Other: _____

Do you think of yourself as:
- □ Bisexual
- □ Gay
- □ Lesbian
- □ Pansexual/polysexual
- □ Straight/Heterosexual
- □ Other _____

What is your preferred pronoun:
- □ He/His
- □ she/Her
- □ Ze/Zhr
- □ They/Theirs
- □ Other: _____

What sex were you assigned at birth:
- □ Female
- □ Male
- □ Intersex

Services are based on a sliding scale according to your income, please report below:
Yearly gross income for your family living in the same household (include persons related by blood, marriage/civil union, or legal adoption) $ _____ Number (including yourself) supported by this income? _____

What type of insurance do you have? (please circle):
Private Medicaid None
Other:_____
Insurance Company:
_____
Address: _____
Phone:_____

Whose name is the policy in?
_____
ID #: _____ Group/Plan #_____
Medicaid #: _____

Do you have secondary Insurance? Y N
Private Medicaid None
Other:_____
Insurance Company:
_____
Address: _____
Phone:_____

Whose name is the policy in?
_____
ID #: _____ Group/Plan #: _____
Medicaid #: _____

If you are 17 years old or younger and covered under your parents' or guardians' insurance plan:
You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder (your parents or guardians) about the health care services you receive at the clinic. Let the clinic staff know if you do not want your parents or guardian to know that you receive services at the clinic.

If you are 18 years old or older and have private insurance coverage and are not the policy holder:
You should know that private insurance companies send out a letter called an explanation of benefits or EOB to the insurance policy holder about the health care services you receive at the clinic. You may contact your insurance company to request that EOBs be sent to you instead of the policy holder to protect your privacy.

(FOR OFFICE USE ONLY)

Client (iCare) ID#_____ Pov. Level: _____% FP Code (circle) 01 02 03 04 05 06 Staff Initials:_____

New FP Client? Y N Existing FP Client? Y N Limited English Proficiency: Y N
(Circle) Insurance: Public Private None Unknown

(Circle) Bill insurance or bill client Confidential Client? Y N